

# CMS Provider and Supplier Enrollment Revalidation Tool Kit Medicare Providers, Suppliers Must Revalidate Enrollment by Early 2013

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## Executive Summary

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to revalidate their enrollment under new risk screening criteria required by the *Patient Protection and Affordable Care Act*, Section 6401(a). (Providers/suppliers who enrolled on or after Friday, March 25, 2011 have already been subject to this screening, and need not revalidate at this time.) Similar requirements apply to Medicaid- or CHIP-enrolled providers/suppliers.

In the continued effort to reduce fraud, waste, and abuse, CMS implemented new screening criteria to the Medicare provider/supplier enrollment process beginning in March 2011. Newly-enrolling and revalidating providers/suppliers are placed in one of three screening categories—limited, moderate, or high. Each screening category represents the level of risk to the Medicare program for a particular type of provider/supplier and determines the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application.

Between now and March 23, 2013, the MACs will be sending notices to individual providers/suppliers; please begin the revalidation process as soon as you hear from your MAC. Upon receipt of the revalidation request, providers/suppliers have 60 days from the date of the notice to update and submit complete enrollment forms (30 days for DMEPOS suppliers). Failure to submit the enrollment forms as requested may result in the deactivation of Medicare provider/supplier billing privileges. The preferred method and quickest way to revalidate enrollment information is to use the Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) at <https://pecos.cms.hhs.gov>.

Payment of a \$505 application fee when enrolling or revalidating is required for any provider/supplier using the following CMS paper-based 855 enrollment applications or associated Internet-based PECOS enrollment applications: 855A, 855B (excluding physicians, physician group practices, non-physician practitioners, and non-physician practitioner groups), and 855S. The fee must be paid via <https://pay.gov>. **Please note:** CMS forms 855A, 855B, 855I, 855O, 855R and 855S all have been revised as of July 1, 2011.

In order to reduce the burden on the provider, CMS is working to develop innovative technologies and streamlined enrollment processes—including Internet-based PECOS. Updates will continue to be shared with the provider community as these efforts progress.

For more complete information about the new provider/supplier revalidation requirements and screening criteria, please continue to review the attached document or for further guidance or assistance, please contact a Dumbarton Group Associate at: [info@dumbartonassociates.com](mailto:info@dumbartonassociates.com).

## Background

Pursuant to the *Patient Protection and Affordable Care Act*, Section 6401(a), new federal regulations released on February 2, 2011 expand CMS authority to combat fraud, waste, and abuse to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The intent of the legislation is to prohibit *unqualified* individuals and entities from obtaining or maintaining enrollment in the Medicare and Medicaid Programs as providers or suppliers; however, legitimate providers and suppliers will need to understand the new requirements so that billing privileges are not affected by a failure to comply with the rules. The final regulations became effective March 25, 2011.

## Enrollment Revalidation

As a result of the new federal regulations, ALL Medicare-enrolled providers or suppliers must re-enroll and resubmit—"revalidate"—the accuracy of their enrollment information every 5 years in order to maintain their Medicare billing privileges (every 3 years for DMEPOS suppliers). Similar requirements apply to Medicaid- or CHIP-enrolled providers/suppliers.

The new enrollment revalidation requirements apply to:

- **Newly-enrolling** Medicare, Medicaid, and CHIP providers and suppliers beginning *on or after* March 25, 2011.
- **Currently-enrolled** Medicare, Medicaid, and CHIP providers and suppliers **adding a new location** (not changing location) beginning *on or after* March 25, 2011.
- **Currently-enrolled** Medicare program providers and suppliers—if enrolled *before* March 25, 2011.
- **Currently-enrolled** Medicaid-only and/or CHIP-only providers and suppliers—if enrolled *before* March 25, 2011.

## Revalidation Process

1. Currently-enrolled Medicare providers/suppliers who have not re-enrolled with the Medicare program since March 2006 (March 2008 for DMEPOS suppliers) should go online and register with the Internet-based provider/supplier enrollment record management system called the Provider Enrollment, Chain, and Ownership System or PECOS.
  - Note: The PECOS system matches provider/supplier information that is maintained in other databases such as an entity's Legal Business Name (LBN) as reported to the Internal Revenue Service or the National Plan and Enumeration System (NPPES) upon obtaining a NPI. If such information is not identically reported, then processing delays will be incurred due to the development method executed by the Medicare Administrative Contractor (MAC) to gather the correct information.
2. Providers/suppliers will receive a letter from the MAC instructing them when revalidation is necessary.
  - Between now and March 23, 2013, the MAC will send out notices on a regular basis to begin the revalidation process for each provider and supplier. Providers and suppliers must wait to submit the revalidation only after being notified by the MAC to do so.

3. Upon receipt of the revalidation letter, providers/suppliers are required to respond to the request and complete the revalidation application within 60 calendar days of notification (30 days for DMEPOS suppliers).
  - If the revalidation application is not completed within the required timeframe, then the provider's/supplier's billing privileges are subject to revocation or deactivation.
  - Completion of the revalidation application requires verifying and updating the provider/supplier enrollment data including any provider/supplier-specific requirements established by Medicare (e.g., licensure, DMEPOS accreditation, surety bonding, credentialing).
    - Submission of specific documentation to verify provider/supplier enrollment data may be required (e.g., IRS Form CP 575 verifying a business entity's tax identification number, pharmacy DMEPOS accreditation attestation of exemption statement).
    - If using PECOS, enrollment forms are not required to be mailed to the MAC, but other supporting documentation that is requested must be mailed to the MAC.
4. Sign the certification statement on the application.
  - Only the authorized official with the authority to sign and certify the initial enrollment application and attest to the veracity of the enrollment data may sign the certification statement on the application. A delegated official does not have this authority. See Resources section at the end of this document for clarification on "authorized" versus "delegated" official.
  - If using PECOS, enrollment forms are not required to be mailed to the MAC, but the signed certification statement and other supporting documentation that is requested must be mailed to the MAC.
5. Pay the non-refundable application fee electronically <https://pay.gov>, either via credit card, debit card, or electronic check, and submit with the application a copy of their **Pay.gov** receipt as proof of payment. For the calendar year 2011, the application fee is \$505. (See also "Application Fee" below for more information.)
  - On the Pay.gov website, enter "CMS" into the field under "Search Public Forms." Click "Go" and then click the link to "CMS Medicare Application Fee."
6. CMS reserves the right to perform unannounced on-site inspections to verify a provider/supplier is operational and to determine compliance with Medicare enrollment requirements. Site verification visits for enrollment purposes are separate from, and in addition to, site visits that may be performed for establishing compliance with conditions of participation. (See also "Screening Requirements" below for more information.)
7. Irrespective of a provider's/supplier's revalidation schedule, any changes in enrollment data must be reported including a change in phone number, business address, provider/supplier credentials, etc., and providers/suppliers must continue to meet the ongoing enrollment requirements for its provider or supplier type including any applicable state licensure or accreditation requirements.

On or after March 23, 2012, CMS may perform interim or "off-cycle" revalidations of its Medicare providers or suppliers and may request a provider or supplier to confirm and recertify the accuracy of their enrollment information maintained by CMS. These off-cycle revalidations are in addition to the regular

5-year revalidations. Off-cycle revalidations may be triggered as a result of random compliance checks, information indicating local health care fraud problems, national initiatives, complaints, or other reasons that cause CMS to question the compliance of the provider or supplier with Medicare enrollment requirements. Interim revalidations may include site visits. CMS will contact providers or suppliers to revalidate their enrollment for an off-cycle revalidation.

CMS also reserves the right to adjust the routine 5-year revalidation schedule to occur on a *more frequent* basis for specific provider or supplier types if it determines that complaints or other evidence it receives indicate noncompliance with the statute or regulations. The revalidation schedule may also be adjusted to occur on a *less frequent* basis if CMS determines compliance with the regulations for a specific provider or supplier type warrant less frequent validation. If a change in the revalidation schedule occurs, CMS will notify all affected providers and suppliers at least 90 days in advance of implementing the change.

### **Application Fee**

Whether revalidating enrollment information, applying for an additional location, or newly enrolling in the Medicare Program, providers and suppliers must pay a non-refundable application fee. The fee is used to cover the cost of CMS's expanded program integrity efforts. Individual physician practitioners or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and physician or non-physician practitioner groups are exempted from paying the application fee. For the calendar year 2011, the application fee is \$505.

Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare enrollment administrative contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The provider/supplier must pay the application fee electronically through **Pay.gov**, either via credit card, debit card, or electronic check. On a regular basis, CMS will send the Medicare enrollment administrative contractors a listing of providers and suppliers (the "Fee Submitter List") that have paid an application fee via **Pay.gov**. However, providers/suppliers are strongly encouraged to submit with their application a copy of their **Pay.gov** receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

### **Medicaid Program**

State Medicaid agencies must revalidate the enrollment of **ALL** providers/suppliers at least every 5 years. The agencies have the discretion to determine which providers or provider types to re-validate enrollment first. However, in the first years of the cycle the agencies may choose to consider re-validating enrollment of provider/supplier types that pose the greatest risk of fraud, waste or abuse to the Medicaid program and CHIP. The agencies should complete the first re-validation cycle by 2015, with 20 percent of providers being re-validated each year beginning 2011. States will also begin collecting the application fee from prospective or re-enrolling providers and suppliers in the Medicaid Program. Providers/suppliers *not* subject to the Medicaid application fee include individual practitioners, providers/suppliers who have paid the application fee in another state's Medicaid program, and Medicare providers/suppliers who have already paid the *Medicare* application fee.

### **Temporary Moratoria on Enrollment of Providers and Suppliers**

Additionally, the new regulations permit CMS to impose a temporary moratorium on newly enrolling Medicare providers and suppliers of a particular type in a specific geographic area if CMS determines that there is a significant potential (high risk) for fraud, waste or abuse with respect to the particular type of provider or within a certain geographic region, or both. The moratorium extends to such providers and suppliers undergoing expansion by establishing new locations, but not to location changes or changes in ownership (except changes in ownership for home health agencies requiring new enrollment). CMS is required to publicly announce any such temporary moratorium in the *Federal Register*.

A moratorium may be based on the identification of trends associated with a significant potential for fraud, waste or abuse within a limited geographic area—a highly disproportionate number of providers or suppliers in a category relative to the number of beneficiaries, a rapid increase in a category’s enrollment applications, a state-imposed moratorium on Medicaid enrollment of a particular type of provider or supplier, or on the recommendation of the HHS OIG, Department of Justice, or GAO identifying a provider or supplier type as having a significant potential for abuse, waste or fraud to the Medicare Program.

If any enrollment application has been approved by a Medicare contractor, then a moratorium will not apply even if the application has not been entered into PECOS. Initial moratoriums may last six months, but CMS may extend a moratorium in six month increments at its discretion. States must also comply with any moratorium issued by CMS by suspending enrollment of a category of providers/suppliers in its Medicaid program, unless the state determines that doing so will adversely affect Medicaid beneficiary access to care.

For all provider/supplier enrollments and revalidations, the applications will be processed in accordance with the screening procedures described below.

### **Screening Requirements**

A MAC is required to screen all applications it receives for initial enrollment, a new location, and in response to a revalidation request.

CMS has defined three screening categories according to a particular type of provider’s or supplier’s risk potential for fraud, waste and abuse—limited, moderate, and high. Provider and supplier types have been assigned to a category based upon a risk assessment by CMS. The level of screening by the MAC on behalf of CMS increases with the category risk potential:

#### **Screening Categories and Screening Requirements**

**Limited:** Providers/suppliers that pose the lowest level of risk will be placed in the "limited" screening category and will be subject to the level of screening currently in effect for this category. Provider/supplier types in the “limited” category include:

- Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and physician and non-physician practitioner medical groups or clinics.
- Ambulatory surgical centers.
- Competitive Acquisition Program/Part B Vendors.
- End-stage renal disease facilities.
- Federally qualified health centers.

- Histocompatibility laboratories.
- Hospitals, including critical access hospitals, Department of Veterans Affairs hospitals, and other federally owned hospital facilities.
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.
- Mammography screening centers.
- Mass immunization roster billers
- Organ procurement organizations.
- Pharmacies newly enrolling or revalidating via the CMS-855B application.
- Radiation therapy centers.
- Religious non-medical health care institutions.
- Rural health clinics.
- Skilled nursing facilities.

The required “limited screening” involves:

1. Verification of any provider/supplier-specific requirements established by Medicare on the provider/supplier enrollment application (e.g., DMEPOS accreditation, surety bonding, pharmacy accreditation attestation exemption statement).
2. License verifications, which may include licensure checks across States (e.g., authentication of licensure and absence of any licensure limitations).
3. “Database checks,” i.e., verification of: Social Security Number (SSN); the National Provider Identifier (NPI); the National Practitioner Data Bank (NPDB) licensure clearinghouse for reports on negative actions or sanctions against health care practitioners and entities; an HHS OIG exclusion from Federal health care programs; taxpayer identification number; and the SSN Death Master File to determine if personnel listed on the application are deceased such as the applicant, owner, authorized official, delegated official, or a supervising physician.

**Moderate:** Providers that pose a moderate level of risk will be placed in the "moderate" screening category and will be subject to all current screening measures imposed on providers/suppliers in the “limited” screening category, as well a mandatory unannounced site verification visit. Provider/supplier types in the “moderate” category include:

- Ambulance service suppliers.
- Community mental health centers.
- Comprehensive outpatient rehabilitation facilities.
- Hospice organizations.
- Independent clinical laboratories.
- Independent diagnostic testing facilities.
- Physical therapists enrolling as individuals or as group practices.
- Portable x-ray suppliers.
- Revalidating home health agencies.
- Revalidating DMEPOS suppliers revalidating via the CMS-855S application including applicable retail, home infusion, and long-term care pharmacies.

The required “moderate screening” involves:

1. All the screening requirements for the “limited” screening category.
2. Mandatory, unscheduled or unannounced site verification visits.
  - Note: Regardless of the provider/supplier screening category, CMS reserves the right to perform on-site inspections to verify a provider/supplier is “operational” and to determine compliance with Medicare enrollment requirements. Site verification visits for enrollment purposes are separate from, and in addition to, site visits that may be performed for establishing compliance with conditions of participation.
  - “Operational” means the provider/supplier:
    - Has a qualified physical practice location;
    - Is open to the public for the purpose of providing health care-related services (if applicable to that provider or supplier type);
    - Is prepared to submit valid Medicare claims; and
    - Is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, supplier specialty, or the services or items being rendered) to furnish these items or services.
    - Reference: CMS Publication 100-08, Program Integrity Manual, Chapter 15, Section 1.1

**High:** Providers that pose the highest level of risk for fraud and abuse will be placed in the "high" screening category and will be subject to all current screening measures imposed on providers/suppliers in the “moderate” screening category and a fingerprint-based criminal background check. (The fingerprint-based criminal background check is postponed for further public input and evaluation.) The provider/supplier types in the "high" risk category include:

- Prospective (newly enrolling) home health agencies.
- Prospective DMEPOS suppliers newly enrolling via the CMS-855S application including applicable retail, home infusion, and long-term care pharmacies.
- Providers/suppliers that have been reassigned from either the "limited" or "moderate" category as a result of a “triggering event,” which is defined as any one of the following:
  - Imposition of a payment suspension within the previous 10 years.
  - Termination or otherwise precluded from billing Medicaid.
  - Exclusion by the HHS Office of Inspector General (OIG).
  - Revocation of billing privileges within the previous 10 years.
  - Exclusion from any federal health care program.
  - Any of the following final adverse actions within the past 10 years:
    - A Medicare-imposed revocation of any Medicare billing privileges;
    - Suspension or revocation of a license to provide health care by any State licensing authority;
    - Revocation or suspension by an accreditation organization;
    - A conviction of a Federal or State felony offense preceding enrollment, revalidation, or re-enrollment; or
    - An exclusion or debarment from participation in a Federal or State health care program.
  - At any time within 6 months from the date a temporary moratorium is lifted for a particular category of providers/suppliers.

The required “high screening” involves:

1. All the screening requirements for the “moderate” screening category.
2. Fingerprint-based criminal history record check of law enforcement repositories. (The fingerprint-based criminal background check is postponed for further public input and evaluation.)

Note: If a provider could fit within more than one risk category described above, the highest level of screening is applicable.

CMS notes that the risk categories are not static and CMS may adjust the classification of providers/suppliers by proposed rulemaking; however, CMS reserves the right to redefine what constitutes a “triggering event” as noted above without formal rulemaking.

### **Medicaid Program**

Individual states will be responsible for implementing the new screening requirements for those providers enrolling only in Medicaid or CHIP. States will be allowed to rely on the screening results obtained by the MACs for providers/suppliers who are seeking dual enrollment in Medicare and Medicaid/CHIP. For Medicaid providers/suppliers that do not participate in the Medicare program, the state Medicaid agencies will have the discretion to evaluate the potential risk of such providers/suppliers and designate a risk category for them. In addition, every state Medicaid agency will now be required to obtain dates of birth and social security numbers for all managing employees of providers/suppliers enrolling in Medicaid.

For further guidance or assistance, please contact a Dumbarton Group Associate at:  
**info@dumbartonassociates.com.**

### **Resources**

***Federal Register Final Rule*** regarding provider/supplier enrollment revalidation and new application/screening criteria titled: “Medicare, Medicaid, and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers,” published February 2, 2011.  
<http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf>

***Code of Federal Regulations*** codification of the above regulations on provider/supplier enrollment revalidation and new application/screening criteria. Go to <http://www.gpoaccess.gov/ecfr>, then Title 42, Public Health, and then click on section 424, Conditions for Medicare Payment, and section 454, Medicaid Enrollment Requirements.

### **Medicare Program Integrity Manual, Chapter 15, Medicare Enrollment**

See the addition of new section 19 titled, “Application Fees and Additional Screening Requirements.”  
<http://www.cms.gov/transmittals/downloads/R371PI.pdf>

### **For Online Information on CMS Medicare Enrollment for Providers and Suppliers**

<http://www.cms.gov/MedicareProviderSupEnroll/>



## Medicare Enrollment Applications

- **Internet-based Provider Enrollment, Chain, and Ownership System (PECOS)**
  - PECOS is the preferred application method for Medicare Provider/Supplier Enrollment and Revalidation. It is an Internet-based, online application version of the paper-based CMS 855 application forms. However, the 855 forms are a good reference and recommended for review to become familiar with the comprehensive enrollment application requirements. The basics of PECOS should also be reviewed prior to accessing it the first time (refer to the below FAQs and applicable educational fact sheets), in addition to reviewing the PECOS checklist that is available upon accessing PECOS online. For online access to PECOS go to: <https://pecos.cms.hhs.gov>
  - **PECOS Frequently Asked Questions (FAQs)**
    - These FAQs are available from Highmark Medicare Services, a Medicare Administrative Contractor (MAC). To access the PECOS FAQs, go to: <https://www.highmarkmedicare.com/enrollment/pecos-faq.html>
- **Form 855B: Clinics/Group Practices and Certain Other Suppliers (For Physician Practitioners/Physicians/Suppliers such as Pharmacies (except DMEPOS Suppliers))**  
<http://www.cms.gov/CMSforms/downloads/cms855b.pdf>
  - Note: If using or referring to the paper-based 855B enrollment form, rely only on the version marked: "Form Approved OMB NO. 0938-0685 (dated 07/11)."
  - MAC List by State: The enrollment administrator for Suppliers, such as pharmacies, is a Medicare Administrative Contractor (MAC). To access the list, go to: [http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact\\_list.pdf](http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf)
- **Form 855S: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers**  
<http://www.cms.gov/cmsforms/downloads/cms855s.pdf>
  - Note: If using or referring to the paper-based 855S enrollment form, rely only on the version marked: "Form Approved OMB No. 0938-1056 (dated 07/11)."
  - The DMEPOS enrollment administrator is the National Supplier Clearinghouse (NSC). Palmetto GBA is the entity under contract with CMS to administer the NSC program. To contact the NSC, go to: <http://www.palmettogba.com/nsc>

## Educational Materials

- **Implementation of Provider Enrollment Provisions in CMS-6028-FC, MLN Matters Number: MM7350**
  - This article is available from the CMS Medicare Learning Network (MLN).\* It provides a summary of the above final rule published in the *Federal Register* on the new provider/supplier enrollment revalidation requirements and screening criteria.
  - <http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf>
- **Further Details on the Revalidation of Provider Enrollment Information, MLN Matters Number: SE1126**
  - This article is available from the CMS MLN and supplements the above MLN article.
  - <https://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf>

- The following educational **Fact Sheets** are available from the CMS MLN. The Fact Sheets are accessible via the CMS MLN product catalog at: <http://www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf>
  - **The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers**
    - Suggested for: Non-physician practitioners, physicians, and other suppliers (except DMEPOS Suppliers) that complete CMS Form 855B.
  - **The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations**
    - Suggested for: Provider and supplier entities (except DMEPOS suppliers) that complete CMS Form 855B.
  - **The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers**
    - Suggested for: DMEPOS suppliers; suppliers that complete CMS Form 855S.
  - **How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)**
    - Suggested for: All Medicare providers and suppliers.

### **CMS Pharmacist Center**

For up-to-date information about the Medicare Program for pharmacists, go to the CMS Pharmacist Center at: <https://www.cms.gov/center/pharmacist.asp>

### **Definitions: Medicare Enrollment Regarding Authorized versus Delegated Official**

An **Authorized Official** means an individual with ownership interest in and/or managing control of the provider/supplier and who is legally responsible for provider/supplier (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) and who has been granted the legal authority to enroll the provider/supplier in the Medicare program, to make changes or updates to the provider's/supplier's status in the Medicare program, and to commit the provider/supplier to fully abide by the statutes, regulations, and program instructions of the Medicare program.

By his/her signature(s), an authorized official binds the provider/supplier to all of the requirements listed in the Medicare Provider/Supplier Enrollment Application Certification Statement and acknowledges that the provider/supplier may be denied entry to or revoked from the Medicare program if any requirements are not met. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the provider/supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing the enrollment application, an authorized official agrees to immediately notify the MAC if any information furnished on the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the MAC of any future changes to the information contained in the enrollment form, after the provider/supplier is enrolled in Medicare, in accordance with the

timeframes established in 42 C.F.R. 424.520(b). (IDTF changes of information must be reported in accordance with 42 C.F.R. 410.33.)

A **Delegated Official** means an individual who is delegated by an authorized official the authority to report changes and updates to the provider's/supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (i.e., the term "person with an ownership or control interest" means, with respect to an entity, a person who—directly or indirectly has an ownership interest of 5% or more in the provider/supplier; or officers and directors of the provider/supplier if the provider/supplier is a corporation (whether for-profit or non-profit); or all individuals with a partnership interest in the provider/supplier regardless of a partner's percentage of ownership; or a managing employee—a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the provider/supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the provider/supplier).

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's/supplier's Medicare status. Even when delegated officials are reported in the enrollment application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature.

Authorized officials and delegated officials must be reported in the revalidation application or on a previous application to the same MAC if a change in authorized and/or delegated officials occurs. **The first time an authorized and/or delegated official is reported, Section 6 of the provider/supplier enrollment application for that individual must be completed and submitted.**

For further guidance or assistance, please contact a Dumbarton Group Associate at: **info@dumbartonassociates.com.**

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